Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-03	3.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client problems information.	Examples of problems information include: Problems Descriptions; Problems Lists; Diagnosis: Name; Coding; Active / inactive status; Associated information (e.g., admission, discharge, chronicity, acute/self-limiting, Etc.); Family type (E.g.., ICD-9 CM, ICD-10 CM, SNOMED-CT, DSM-IVR; Etc.); ; Effective Start / Stop dates for diagnosis; Etc. Displays should be user-friendly (e.g., Display of both diagnosis code and name; option to display diagnosis description; Etc.) See Practice Management 43.006 and Infrastructure 43.040	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E
F-03	3.002	The system shall provide the ability to maintain a history of all problems associated with a client.	This means both current and inactive and/or resolved problems. These may be viewed on separate screens or the same screen. Ideally each discrete problem would be listed once.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E
F-03	3.005	The system shall be able to record the user ID and date of all updates to documented client problems.		E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E
F-03	3.006	The system shall be able to associate orders, medications, and care documentation (e.g., notes) with one or more problems.	Implies ability to associate a visit with a particular diagnosis / problem. Association may be in a structured or non-structured data format.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-03	3.009	The system shall be able to validate diagnosis information to be used in the system.	Examples of validation include: Diagnosis is valid for an associated axis; Diagnosis is active for an associated time period; User authorized to enter diagnosis information; Etc.	E	E	M	E	E	E	E	NA	E	NA	E	NA	E	E	E	E	E	E	NA	NA	E	E	E
F-03	3.012	The system shall provide the ability to separately display active problems from inactive/resolved problems.		E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E
F-03	3.013	The system shall support multiple diagnosis standards.	Examples include: DSM IV and ICD-9, ICD-10 diagnoses. Includes any necessary translations of code to code formats.	E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	P	E	E	E	E	E	E	E
F-03	3.016	The system shall be able to manually order a problem list.		E	E		E	E	E	E	NA	E	NA	E	E	E	E	E	E	M	M	NA	C	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication lists information.	Examples of medication lists include: Lists based on frequency of medication usage; healthcare service provider medication preferences; etc. Examples of medication list information include: Medication name; dose; route; sig,;dispense amount; refills; associated diagnoses; medication expiration date; medication labeling as ineffective for client, Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information, etc. Implies medication information is stored in discrete data fields and only approved abbreviations shall be used. The medication list shall be "client-centric" and shall include medications prescribed by any provider. Display and printing of information may be controlled through user-selected parameters (e.g., client identifier, date ranges, which information to display, current and/or inactive medication status, brand or generic name of medication, etc.) See Practice Management 43.006 and Infrastructure 43.040	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	3	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.002	The system shall be able to indicate that the medication list has been reviewed by both the healthcare service provider and client.	Implies usage of a discrete data record field.	E	E	NA	E	E	E	E	NA	NA	NA	E	E	E	P	E	E	M	M	NA	E	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.003	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all prescribed medication-related information.	▪ Examples of information include: Client prescriptions; Prescribed medications; Non-prescribed medications (e.g.,over the counter and complementary medications such as vitamins, herbs and supplements); Standard medication codes (e.g., NDC number codes); Free text or uncoded medications; Medication name, schedule, quantity, dosage, order date, date last taken, side effects, and effectiveness; Client identifiers; Medication start, end, and renewal dates; Refill quantity; Prescriber identity; Fact that client takes no medications; Reasons for taking, not taking, or discontinuing medication; Source of medication information or history; Date of any change made to medication information (including a medication list); Identification of user who made any change to medication information; Medication contra-indication, Active problem interaction; etc. ▪ Implies medication information is stored in discrete data fields and only approved abbreviations shall be used. ▪ Copying implies ability to "cut and paste" or otherwise import/export medication information with another data record or document. Example includes: copying medication information into a client progress notation. ▪ Display and printing of information may be controlled through user-selected parameters (e.g., client identifier, date ranges, which information to display, current and/or inactive medication status, brand or generic name of medication, etc.) ▪ It is important to have all current medications in the system for drug interaction checking. It includes non-prescription drug interactions (e.g., associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome); It includes medication history obtained from external electronic interfaces, e.g., from insurers, PBMs, etc. "User" means medical and non-medical staff who are authorized by policy to enter prescriptions or other documentation. ▪ Allowing entry of free text medications (e.g., blue hypertension pill) or uncoded medications (e.g., Synthroid unknown dose) is important when medications are not on the vendor-provided medication database or information is insufficient to completely identify the medication. ▪ See Practice Management 43.006 and Infrastructure 43.040	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	3	E	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.005	The system shall support medication monitoring.	Examples of support include: User-friendly linkage/navigation to Diagnostic Test Order screens; Provider notification when test results are obtained; Etc. Linked to 14.001	M	E	NA	E	E	E	E	NA	E	NA	E	E	M	E	E	E	E	M	P	E	P	E	E
F-04	4.007	The system shall be able to display and print medication history for the client.	Examples of medication history include: Client system identifier and name; medication name, frequency, effective start date and end date, and dosage; Range of dates for history.	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	P	E	E	E	E
F-04	4.011	The system shall provide the ability to enter non-prescription medications, including over the counter and complementary medications such as vitamins, herbs and supplements.	This is important for interaction checking, associating symptoms with supplements e.g. the L-trytophan related eosinophila-myalgia syndrome	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	3	E	E	E	E	E
F-04	4.013	The system shall be able to exclude a medication from the current medication list and document the reason for such action.	Exclusion examples include: medications marked inactive, erroneous, completed, discontinued. Documentation includes identifying the clinical authority authorizing exclusion.	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	3	E	3	E	E
F-04	4.025	The system shall be able to notify healthcare service providers that client's prescribed medication might be running out.	Implies controlling notifications through business rules; Queries that search for expiring/expired prescriptions; Etc.	M	E	NA	E	E	E	E	NA	P	NA	E	NA	E	E	M	M	M	E	P	C	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   \<blank\> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.026	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication information in any medication formulary list.	Examples of lists include: Medication formulary for entire organization; Medication formulary defined by client classification, funding, Scope of Practice, Etc. Example of information in lists include: Medication name; Type of list (e.g., agency wide, client classification specific, Etc.); Medication choice prioritization; Medication costs: Etc..	M	3	NA	E	E	E	E	NA	E	NA	E	E	M	E	E	M	E	3	3	C	3	E	3
F-04	4.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication formulary rules and guidelines.	Examples of rules include: List access; Formulary usage is optional or required criteria; Effective stop / start dates of formulary usage; Etc. Guidelines may be reference documents.	M	3	E	E	E	E	E	NA	NA	NA	E	E	M	M	E	M	M	3	NA	C	3	E	E
F-04	4.028	The system shall include access to the National Drug Code (NDC) database.		M	3	M	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	3	3	NA	3	E	E
F-04	4.029	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print commonly used prescription templates.	Examples of prescription templates include: Templates defined for different healthcare service providers; Etc.	M	3	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	M	E	3	E	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;
M = with Modification;
C = Custom;
3 = 3rd Party;
NA = Not Addressed;
<blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-04	4.037	The system shall support client involvement in a Physician Assistance Program (PAP).	Examples of support include: Prompting a healthcare service provider to discuss participation with the client; Providing data fields to record information on client's involvement; Providing reminders when the application renewal is due; Etc. See Practice Management 32.016	M	M	NA	E	E	P	E	NA	NA	NA	E	E	M	E	E	E	M	M	NA	E	3	E	E
F-05	5.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on medications and other agents to which the client has had an allergic or other adverse reaction.	Examples of information include: Any combination of provider / client defined allergy / adverse reactions lists; Client identifiers; Medication names; Type and severity of allergic or adverse reaction; Reason and authority for action taken on information (i.e., modification, inactivation, Etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g., Client, relative, friend, healthcare service provider, etc.) "Inactivate" in this context implies specifying that an allergy or allergen specification is no longer valid or active as opposed to deleting the information from the database entirely. The user ID, date & time will be recorded per Security requirements. See Practice Management 43.006 and Infrastructure 43.040	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	3	E	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-05	5.009	The system shall be able to document review of any allergy or adverse reaction list.	Examples of review documentation include: Reviewer User Identifier; Date stamp of when review option is selected. Medico-legal and regulatory compliance. This requires the user to explicitly select this option documenting that they have reviewed the allergies with the client. Implies documentation will be in a structured format.	M	E	E	E	E	E	NA	NA	NA	E	E	M	E	E	E	E	M	NA	C	E	E	E	
F-05	5.011	The system shall be able to explicitly indicate that a client has no known drug allergies.	Medico-legal and regulatory compliance. This is meant to be specific to drug allergies. Expected to be available by 2008.	P	E	M	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	3	E	E	E	E
F-05	5.012	The system shall be able to explicitly indicate that a client has no known non drug allergies.	Expected to be available by 2008.	P	E	M	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	3	E	E	E	E
F-05	5.015	The system shall be able to check for potential interactions between a current medication and a newly entered allergy.		P	3	3	E	E	E	E	NA	P	NA	E	E	E	M	E	M	M	3	3	NA	3	E	E
F-05	5.016	The system shall interface with third party databases that support automated drug allergy checking to be performed during the medication prescribing process.		P	3	3	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	3	3	NA	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-05	5.017	The system shall provide the ability to capture non-drug agents to which the client has had an allergic or other adverse reaction.	These could include items such as foods or environmental agents. This need not be accomplished within the same portion of the chart where medication allergies are noted.	M	E	E	E	E	E	E	NA	E	NA	E	E	E	M	E	E	E	E	3	E	E	E	E
F-06	6.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client history information.	Examples of client history include: Services / Treatments; Healthcare service provider identifiers; Medical conditions; Diagnoses; Medical procedures; Immunizations; Date / Times of actions on history data (i.e., additions, modification, inactivation, etc.); Family history; Social history; Hospitalizations; Specific absence of a condition or family history of the condition; Reason and authority for action taken on information (i.e., modification, inactivation, etc.); Date action taken on information; User identifier who took action on information; Source references for information (e.g.,Client, relative, friend, healthcare service provider, etc.); Episodes of care; Prior client or provider alerts, vital signs recordings, client messages, chronic diseases, Post discharge contact information; etc. Episodes of care are based on state and local definitions. Generally, they are by periods of care at a provider, geographical, or organizational level; They may be outpatient or inpatient based and may exist concurrent with other episodes of care.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	NA	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-06	6.002	The system shall capture client history information in a structured data format.		E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-07	7.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print summary list information for each client.	Data may be in a standard and non-standard coded form.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	NA	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all healthcare service provider documentation in system. All actions on documentation shall cause a recording of the date / time of the action and the identit	Examples of provider documentation include information in: Healthcare service provider assessments, notes, care plans, progress notes, wellness and recovery plans, Etc. Examples of documentation information include: Client name, Identifier of who entered data, age, gender, problem(s), medical necessity, current and prior healthcare service providers, risk factors, family medical history; Physical health attributes (e.g., client vital signs, blood pressure; temperature; heart rate, respiratory rate, height, and weight, and physical pain levels); Free text notes; Nationally recognized mental/behavioral health care plans and alerts; Language used by client; provider's explanation (and the client understanding) of recommended and/or alternative care plans; Actions taken to safeguard the client to avert the occurrence of morbidity, trauma, infection, or condition deterioration; Problem lists for adults and children; Global Assessment of Functioning (GAF) values; Children Global Assessment Scale (CGAS) scores; Etc.	M	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-08	8.003	The system shall be able to save, and later retrieve, healthcare service provider documentation in progress.	Display of information may include linkages to multiple system database records (e.g., Diagnosis, Allergies, Service / Treatment, etc.)	E	E	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	E	E	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.005	The system shall be able to finalize healthcare service provider documentation, i.e., change the status of the documentation from in progress to complete. Subsequent actions will not destroy any of the original finalized documentation, i.e., strikeouts		E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-08	8.007	The system shall support electronic signatures and co-signatures in documentation.	See Practice Management 43.006 and Infrastructure 43.040	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	M	E	E	E	E	E	E	E
F-08	8.008	The system shall be able to addend to documentation that has been finalized.		E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-08	8.009	The system shall be able to identify, display and print the full content of a modified documentation.	Implies display and printing of both the original content and the content resulting after any changes, corrections, clarifications, addenda, etc. to a finalized documentation.	E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-08	8.015	The system shall be able to graph client attributes over time.	Examples include: height and weight; Calculated body mass index (BMI); Etc.	M	E	E	E	E	E	P	NA	P	NA	E	E	3	E	E	E	P	M	P	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.017	The system shall be able to compare body mass index (BMI) to standard norms for age and sex over time.		M	P	E	E	E	E	E	NA	E	NA	E	E	3	M	E	E	P	M	P	E	M	E	E
F-08	8.018	The system shall be able to indicate to the user when a vital sign measurement falls outside a preset normal range.	Implies that authorized users shall set the normal ranges.	M	P	NA	E	E	E	E	NA	E	NA	E	E	3	P	E	E	P	M	P	E	M	E	E
F-08	8.019	The system shall be able to associate standard codes with discrete data elements in a documentation.	Examples of standard codes include but are not limited to SNOMED-CT, ICD-9 CM, ICD-10 CM, DSM-IV, CPT-4, MEDCIN, and LOINC. This would allow symptoms to be associated with SNOMED terms, labs with LOINC codes, etc. The code associated with a note would remain static even if the code is updated in the future.	E	E	NA	E	E	E	E	NA	NA	NA	E	E	M	E	E	E	E	E	E	E	E	E	E
F-08	8.02	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print structured templates for healthcare service provider documentation.	Examples of templates include: Structured progress notes; Intake assessments such as the mini mental health exam; Care Plans; Wellness and Recovery Plans; Etc. User ability to customize templates is preferred. Codified data are data that is structured AND codified according to some 'external' industry accepted standard such as ICD-9 CM, ICD-10 CM, SNOMED-CT, and CPT-4.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;
M = with Modification;
C = Custom;
3 = 3rd Party;
NA = Not Addressed;
<blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.023	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print comments by the client or the client's representative (henceforth 'client annotations') regarding the accuracy or veracity of information in the client record.	This includes external documentation incorporated in the client records. 2007 it is sufficient for these to be recorded as either free-text notes (see item F59) or scanned paper documents (see item F86). It is not required that the system facilitate direct entry into the system by the client or client's representative.	P	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-08	8.024	The system shall display client annotations in a manner which distinguishes them from other content in the system.	Examples of displays include: Use of a different font or text color; A text label on the screen indicating that the comments are from a client or client's representative; Etc. "Distinguishable" refers specifically to comments made by the client or client's representative, but does not refer to the individual components of that chart with which they are in disagreement.	E	E	NA	NA	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	E	E	E	E
F-08	8.025	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client or client proxy completed clinical information.	Once verified by a healthcare service provider and shared with other parts of the chart, the shared data does not need to be identified as client completed in all sections where data may be shared, but the original client completed information shall be maintained.	M	M	NA	E	E	E	E	NA	E	NA	E	E	E	E	M	P	E	M	E	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.027	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print group activity documentation.	Examples of group activity include: Outpatient and Inpatient group therapy sessions; Group therapy sessions funded by multiple funding streams (E.g., Mental Health / Alcohol and Drug); Etc. Implies the ability to handle both documentation common to all participants and documentation distinct to an individual participant.	E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	M	P	E	E	E	C	E	E	E
F-08	8.035	The system shall be able to interface with 3rd party products which support documentation.	Examples of products include: Various standard intake assessment instruments; Medical dictionary; Etc.	M	M	M	E	M	E	C	NA	E	NA	E	E	E	E	M	E	M	E	E	E	E	E	E
F-08	8.044	The system shall provide a location check log that supports the tracking of clients by location.	Examples of client checking include: Client checking on a user-defined basis (e.g. every 5 or 10 minutes). This component is used primarily at inpatient facilities.	M	M	NA	E	E	E	E	NA	E	NA	E	E	E	E	M	E	E	E	M	M	C	M	E
F-08	8.047	The system shall be able to merge client healthcare service provider documentation.	Examples of reasons for merge include: Documentation created under two separate client identifiers but its really for the same client. Does not have to be only duplicate data found in both records.	E	E	E	E	E	P	NA	E	NA	E	E	E	P	E	E	E	M	P	C	P	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   \<blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.048	The system shall be able to display and review all data in two similar type client healthcare service provider documentation records for the same client, identifying the data that is different.	This will support determining the correct client health record information that should exist subsequent to merging two records to one.	E	E	NA	E	E	E	P	NA	E	NA	E	E	E	P	E	E	E	E	M	C	P	E	E
F-08	8.049	The system shall require user confirmation prior to merging any client healthcare service documentation.		E	E	E	E	E	E	P	NA	E	NA	E	E	E	P	E	E	E	E	P	C	E	E	E
F-08	8.05	The system shall be able to recreate as separate documentation records previously merged client healthcare service provider documentation.		E	E	NA	E	E	E	P	NA	E	NA	E	E	M	P	E	E	E	C	P	C	E	E	E
F-08	8.064	The system shall support healthcare service provider Report Dictation.	Examples of support include: Voice capture and storage; Routing of voice to transcribers; Integration of audio files with documentation; Usage across various parts of EHR system; Software produced voice to text transcriptions; Usage of nationally recognized best practice dictation software solutions; Etc. Also supported by 8.001 and Infrastructure 43.040	M	E	3	E	3	E	E	NA	E	NA	E	E	M	E	E	E	3	M	M	E	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;
M = with Modification;
C = Custom;
3 = 3rd Party;
NA = Not Addressed;
<blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-08	8.074	The system shall provide the ability to capture other clinical data elements, such as peak expiratory flow rate, size of lesions, severity of pain, as discrete data		E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	M	E	E	M	E
F-08	8.075	The system shall provide the ability to display other discrete numeric clinical data elements, such as peak expiratory flow rate or pain scores, in tabular and graphical form.	Listed items are examples only.	M	M	NA	E	E	E	P	NA	NA	NA	E	E	E	E	E	E	E	E	M	E	M	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-09	9.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print external healthcare service provider documentation.	Examples of external documents or their content include: Scanned documents; Electronically submitted documents (e.g., faxes; downloads; etc.); Structured reports (e.g., text-based fields; standard and non-standard codified data, etc.) ; Referral authorizations; Consultant reports; Client correspondence of a clinical nature; External test results (e.g., Labs; X-rays; Physical exams, etc.); Medication detail (e.g., Pharmacy, client, and provider identifiers, medication strength, dosage, Dr. directions; etc.;); Originator of document; Etc. Examples of input documents formats include: Storing as a file of various electronic formats (E.g., .PDF, .Doc, .XLS, .JPG, .TIF, .MPEG, .WAV, .MP3, etc.); Integrating as text or image documents into EHR records / screens; integration through web-links; Etc. Images may include but are not limited to radiographic, digital or graphical images. Examples of document support for EHR system include: Indexing (for retrieval) methodologies; Web-links; Date / Time stamping; Etc. See Practice Management 43.006 and Infrastructure 43.040.	P	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-09	9.005	The system shall be able to index documents.	Examples of types of indexing include: Document type; Date of the original document; Date of scanning; Subject and title.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; \<blank\> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-10	10.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print client instructions and client educational materials.	Examples of client instructions and educational materials include: Medication instructions; Tests and procedures instructions; Vaccine instructions; Care access instructions; Etc.) Implies material would be culturally competent and in county threshold languages. See Infrastructure 43.040 and Practice Management 43.006	E	M	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	P	C	E	E	E
F-10	10.004	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print that client specific instructions or educational material were provided to the client.	Implies material would be culturally competent and in county threshold languages. This does not require automatic documentation.	M	M	E	E	E	E	E	NA	E	NA	E	E	M	E	E	E	E	E	P	E	P	E	E
F-10	10.01	The system shall be able to link client instructions to other system functions and enable automated printing of instructions.	Examples of system functions include: Management of client care plans, client orders, client scheduling, provider practice guidelines; Etc.	M	NA	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	M	E	NA	E	P	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-10	10.012	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print a Crisis Management Plan.	Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager. Implies integration with other system functions. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client. See Practice Management 43.006	E	E	NA	E	E	E	E	NA	P	NA	E	E	E	E	E	M	E	E	E	E	E	E	E
F-10	10.013	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print an Advance Directives Plan.	Examples of advance directives include: Client healthcare service provider preferences; Medication limitations; notifications to relatives or guardians; Etc.; Implies that: Plan structure may defined by user; Plan may be prepared by the client and their case manager. Implies integration with other system functions. If a client goes into crisis this plan is easily accessible to provide guidance to staff on the care team and other providers who have contact with the client. See Practice Management 43.006	E	E	NA	E	E	E	E	NA	P	NA	E	E	E	E	E	M	E	M	E	E	P	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-14	14.001	The system shall provide the ability to input, modify, inactivate, delete, update, display, copy, and print results information.	Examples of results information include: Client identifier(s); Linkage to original order information; Test and Result types; Test dates; Result source; Result receipt date; Result type: (E.g., X-ray, lab, vital sign; Etc.); Result status (E.g., normal vs. abnormal status by county definition and/or original data source definition); Effective start/stop date; Result related documentation (E.g., Image documents, Consultation notes, Diabetes education; Etc.;); Client or provider commentary regarding results; alerts identifying a modification to the test or procedure; Etc. Displays may be as numeric or textual data and sorted / filtered by variable criteria (client group identifier, client identifier or multiple client identifiers, test type, test date, normal/abnormal status, etc.); Abnormal data may be highlighted for ease of viewing; See Practice Management 43.006 and Infrastructure 43.040	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	M	P	C	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-14	14.002	The system shall be able to compare results over time.	Examples of result comparisons include: A clients test results to client's own baseline results, organizational baseline results; prior client results, other client results, national standards results, comparisons with prescription and other client data in system; Visual comparison of lab results to prescription information, Etc.; Display may be in numeric flow sheets and/or graphical form. System should indicate if abnormal results are high or low.	P	M	E	E	E	E	E	NA	P	NA	E	E	E	E	E	E	E	M	P	E	3	E	E
F-14	14.007	The system shall be able to forward a result.	Examples of who may receive the forwarded result include: healthcare service providers; the client; Etc.	M	E	E	E	E	E	E	NA	P	NA	E	E	M	E	E	E	E	M	P	C	3	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-16	16.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print care plan, protocol, and guideline documents.	Examples of guideline documents include: Standard documents; Site-specific documents; Clinical Trial Protocols; Psycho-social assessments, Intake assessments, Addiction Severity Index (ASI), inpatient evaluations, Residential placement evaluations; Etc. Clinical trial protocols may be used to ensure compliance. These documents may reside within the system or be provided through links to external sources. They may be nationally recognized documents. This requirement could be met by simply including links or access to a text document. Road map would require more comprehensive decision support in the future. This includes the use of clinical trial protocols to ensure compliance. See Practice Management 43.006 and Infrastructure 43.040.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	M	C	E	E	E	E	E
F-17	17.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print the reason for variation from care plans, guidelines, and protocols as discrete data.	See Practice Management 43.006 and Infrastructure 43.040.	E	E	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	P	M	M	P	C	M	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-19	19.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print medication administration information.	Example of medication administration information includes: Medication type; Dose; Time of administration; Route; Site; Lot number; Expiration date; manufacturer; Person who administered medication; Data entry user ID. Data shall be stored as discrete data fields. See Practice Management 43.006 and Infrastructure 43.040.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	P	E	M	E	E
F-19	19.003	The system shall provide the ability to document immunization administration.		E	E	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	E	M	E	E
F-19	19.004	The system shall provide the ability to document, for any immunization, the immunization type, dose, time of administration, route, site, lot number, expiration date, manufacturer, and user ID as structured documentation.		E	E	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	E	M	E	E
F-19	19.005	The system shall provide the ability to record an adverse reaction to a specific immunization.	Immunization allergies may be indicated in the Allergy section.	E	E	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	E	M	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-19	19.006	The system shall provide the ability to alert a user at the time of ordering that the client had a prior adverse reaction to that immunization.		M	P	M	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	M	M	P	C	M	E	E
F-21	21.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print information on criteria guidelines for disease management, preventive services, and wellness alerts.	Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.); Implies that guidelines are interfaced with organization's business rules. The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive alerts (e.g., contact care provider without physician intervention); Come from national organizations, medical societies, etc. See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.	E	NA	NA	E	E	E	E	NA	P	NA	E	E	E	E	E	E	M	M	P	C	E	E	E
F-21	21.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print alerts based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012	E	NA	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	M	M	P	C	P	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-21	21.006	The system shall be able to override guideline alerts.	Includes all or part of the alerts.	E	NA	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	C	M	E	P
F-21	21.007	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print reasons alerts were overridden.	Needed for medico-legal reasons and clinical decision support.	M	NA	NA	E	E	E	E	NA	NA	NA	E	E	M	E	E	E	E	M	P	C	M	E	P
F-21	21.009	The system shall trigger clinical alerts that present urgent clinical information.	Examples of urgent clinical information include: Danger warnings, suicide watch or similar, drug allergies, history of adverse reactions to specific drugs, and other urgent precautions. Examples of alerts types include: Clinical alerts for incarcerated clients (e.g., suicide watch, drug dealing, and protective custody Alerts to be viewed at various key screens including those that handle progress notes, appointments and service/Care Plans. See Practice Management 43.009, 43.010, and 43.012.	M	M	NA	E	E	E	E	NA	P	NA	E	E	E	E	E	P	E	M	P	E	P	E	E
F-21	21.022	The system shall provide the ability to document that a preventive or disease management service has been performed based on activities documented in the record (e.g., vitals signs taken).		E	E	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	E	C	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-21	21.023	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This could include services performed internally or external to the practice.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	C	E	E	E
F-21	21.024	The system shall provide the ability to document that a disease management or preventive service has been performed with associated dates or other relevant details recorded.	This is done at the client level. Examples include but are not limited to: *Remove mammography for woman that has had a mastectomy *Remove annual pap smear alert for a woman who has had a complete hysterectomy. *Inactivate an alert for routine colon cancer screening in a client who is terminally ill.	E	NA	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	C	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-22	22.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print criteria information for disease management, preventative services, and wellness notifications and reminders.	Examples of criteria information include: Client demographic data (minimally age and gender); Clinical data (e.g., problem list, current medications, Etc.) Implies guidelines are interfaced with organization's business rules. The criteria guidelines may: Be internal or external based; Use clinical trial protocols to ensure compliance; Cause automatic and proactive notifications and reminders (e.g., contact client without physician intervention); Come from national organizations, medical societies, etc. See Practice Management 43.006, 43.009, 43.010 and Infrastructure 43.040.	E	NA	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	M	E	P	C	M	E	E
F-22	22.002	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print notifications and reminders based on established guidelines.	Guidelines may be from national organizations, payers, or internal protocols. See Practice Management 43.012	E	M	E	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	M	E	P	C	P	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;
M = with Modification;
C = Custom;

3 = 3rd Party;
NA = Not Addressed;
<blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-22	22.004	The system shall trigger clinical notifications and reminders.	Examples of clinical notifications and reminders include: One or more clients are due or overdue for disease management, preventive, or wellness service / treatments; See Practice Management 43.009, 43.010, 43.012, and Infrastructure 43.040.	E	E	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	E	P	C	P	E	E
F-22	22.007	The system shall be able to override guideline notifications and reminders.	Includes all or part of the notifications and reminders.	E	E	NA	E	E	E	E	NA	NA	NA	E	E	E	M	E	E	E	M	P	C	M	E	E
F-22	22.009	The system shall provide the ability to display reminders for disease management, preventive, and wellness services in the client record.	It is expected that in the future discrete data elements from other areas of the chart will populate matching fields.	E	NA	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	C	M	E	E
F-22	22.01	The system shall provide the ability to identify criteria for disease management, preventive, and wellness services based on client demographic data (age, gender).		M	E	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	C	M	E	E
F-29	29.001	The system shall be able to define one or more reports as the formal Health Record for disclosure purposes.	This allows the practice to not print demographics, certain confidential sections, or other items. Report format may be plain text initially. In the future there will be a need for structured reports as interoperability standards evolve.	M	E	NA	E	E	E	E	NA	NA	NA	E	E	E	E	E	E	E	M	P	C	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-29	29.002	The system shall be able to generate hardcopy or electronic output of part or all of the individual client's Health Record.	This could include but is not limited to the ability to generate standardized reports needed for work, school, or athletic participation.	E	M	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	E	E	E	E	E
F-29	29.003	The system shall be able to generate Health Record hardcopy and electronic output by date and/or date range.		M	M	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	M	E	M	E	E	E	P

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned; 3 = 3rd Party;
M = with Modification; NA = Not Addressed;
C = Custom; <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-29	29.004	The system shall be able to export structured data which removes those identifiers listed in the HIPAA definition of a limited dataset. This export on hardcopy and electronic output leaves the actual PHI data unmodified in the original record.	De-identifying data on hardcopy or electronic output is necessary for research. However, it is emphasized that this function is not intended to cleanse the text in the note or data in the original record. As per HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, identifiers that shall be removed are: 1. Names; 2. Postal address information, other than town or city, state and zip code; 3. Telephone numbers; 4. Fax numbers; 5. Electronic mail addresses; 6. Social security numbers; 7. Health record numbers; 8. Health plan beneficiary numbers; 9. Account numbers; 10. Certificate/license numbers; 11. Vehicle identifiers and serial numbers, including license plate numbers; 12. Device identifiers and serial numbers; 13. Web Universal Resource Locators (URLs); 14. Internet Protocol (IP) address numbers; 15. Biometric identifiers, including finger and voice prints; and 16. Full face photographic images and any comparable images.	E	M	NA	E	E	E	E	NA	NA	NA	E	E	E	E	M	E	M	E	M	E	E	C	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Heath	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-29	29.006	The system shall have the ability to provide support for disclosure management in compliance with HIPAA and applicable law.	This criterion may be satisfied by providing the ability to create a note in the client's record. More advanced functionality may be market differentiators or requirements in later years.	E	E	E	E	E	E	E	NA	E	NA	E	NA	E	E	E	E	E	E	M	E	E	E	E
F-30	30.001	The system shall be able to input, modify, inactivate, delete, update, display, copy, and print all client service / treatment information.	Examples of service / treatment information include: Information entry by keyboard; Structured data entry utilizing templates, forms, pick lists or macro substitution; Dictation with subsequent transcription of voice to text, either manually or via voice recognition system. See Infrastructure: 43.040.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	E	E	E	E
F-30	30.003	The system shall be able to associate individual service / treatments with diagnoses.		E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	E	E	E	E
F-30	30.004	The system shall have the ability to provide filtered displays of service / treatments.	Examples of filtered displays include: Display by date of service; healthcare service provider; associated diagnosis; Etc.	E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	M	E	E	E	E	E
F-34	34.001	The system shall be able to update the clinical content or rules utilized to generate clinical decision support notifications, reminders and alerts.	Growth charts, CPT-4 codes, drug interactions would be an example. Any method of updating would be acceptable. Content could be third party or customer created.	E	E	E	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	P	E	P	E	E	E

Clinical Data – 98 Requirements:

Includes clinical documentation such as assessment, treatment notes, and other clinical measures (such as data elements and corresponding definitions) that can be used in the measurement of patient clinical management and outcomes, and for research and assessment. Clinical documentation elements also help facilitate communication across provider types to enhance communication and improve coordination of care.

E = Exisiting;
P = Planned;   3 = 3rd Party;
M = with Modification;   NA = Not Addressed;
C = Custom;   <blank> = No Response

Req. Ctgy.	Req. Nbr.	Requirements Description	DMH Comments	Anasazi Software	Askesis Dev Group	Benchmark Sys	Cerner Corp	Defran Sys	Duke BH Informatics	Eclipsys Practice Solutions	eWebHealth	ICANotes	InterComponentWare	Libera	McKesson	Netsmart NY	NextStep	Noteworthy Medical Sys	OCHIN	Orion Health	PCE Systems	Platton Technologies	Raintree Sys	The Echo Group	UNI/Care Sys	Universal
F-34	34.002	The system shall be able to update clinical decision support guidelines and associated reference material.	Any method of updating would be acceptable. Content could be third party or customer created.	E	E	NA	E	E	E	E	NA	E	NA	E	E	E	E	E	E	E	E	P	E	P	E	E
I-04	4.001	The system shall be able to send a report of client immunizations to an immunization registry	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.	M	NA	NA	E	E	E	E	NA	NA	NA	E	E	M	M	E	E	E	3	P	C	M	E	E
I-04	4.002	The system shall be able to retrieve immunization registry information and import immunization record information into the EHR	State immunization registries are not using uniform national standards at this time. The CVX and MVX vocabularies constitute an option for representing immunizations, but have not been addressed by HITSP at this time. Working Group will evaluate standards and options for future versions of HL7.	M	NA	NA	E	M	E	P	NA	NA	NA	E	E	M	M	E	E	E	M	P	C	M	E	P